



Employer Name	Effective Date ____/____/____	Date of Hire ____/____/____	Event Description <input type="checkbox"/> Hire/Rehire <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Termination <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA/Extension <input type="checkbox"/> Other
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EMPLOYEE INFORMATION (*indicates required field)			
*First Name, Middle Initial, Last Name	*Date of Birth / /	*Gender <input type="checkbox"/> M <input type="checkbox"/> F	*Social Security #
*Mailing Address: City, State, Zip		*Phone Number	Annual Salary

DEPENDENT INFORMATION (*indicates required field)						
*Add or Delete (Circle One)	*Name of Dependent (If dependent has different mailing address, please attach) First name, Middle initial, Last name	*Birth Date (Children age 26 or over requires certificate)	*Gender (Circle One)	*Social Security #	Prior Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (if 'Yes' indicate on Page 2)	* PCP ID Number
Add/Delete	Spouse/Registered Domestic Partner	/ /	M F			
Add/Delete	Child	/ /	M F			
Add/Delete	Child	/ /	M F			
Add/Delete	Child	/ /	M F			
Add/Delete	Child	/ /	M F			

For individuals who are eligible for enrollment in an employer group health plan: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or employer group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if, in the case of employer group health plan coverage, the employer stops contributing toward you or your dependents' other coverage.) However, you should request enrollment within 60 Days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you gain a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you should request enrollment 60 days after the marriage, birth, adoption, or date of assumption of total or partial legal obligation for support of a child in anticipation of adoption.



Business Health Trust Employee Enrollment Change Form 2010 – 2011



PLAN SELECTIONS		
Medical and Prescription Drug (Rx) Plan Selection <i>If no coverage selected, attach waiver form. For non-HSA Asuris plans, one Rx options must be selected.</i>	Underwritten by Asuris Northwest Health – Medical Options: <input type="checkbox"/> Progressive \$0 <input type="checkbox"/> Progressive \$200 <input type="checkbox"/> Progressive \$500 <input type="checkbox"/> Progressive \$650 <input type="checkbox"/> HSA \$1,500 <input type="checkbox"/> HSA \$2,500 <input type="checkbox"/> Infinity \$200 <input type="checkbox"/> Infinity \$300 <input type="checkbox"/> Infinity \$500 <input type="checkbox"/> Infinity \$1,000 <input type="checkbox"/> Infinity \$2,000 <input type="checkbox"/> Infinity \$3,000	
	Underwritten by Asuris Northwest Health – Rx Options: <input type="checkbox"/> \$10/\$20/\$40 2x mail <input type="checkbox"/> \$10/\$25/\$50 3x mail MAC A <input type="checkbox"/> \$10/\$35/\$70 3x mail MAC A <input type="checkbox"/> \$10/\$35/\$70 \$150 brand deductible 3x mail MAC A Underwritten by Group Health Options Inc: Alliant Plus: <input type="checkbox"/> \$200 Balance <input type="checkbox"/> \$500 Mid Plan <input type="checkbox"/> \$1,000 Balance Plan <input type="checkbox"/> \$3,000 50/50 Plan	
Dental Plan Selection	Underwritten by Washington Dental Service: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan AA <input type="checkbox"/> Plan C <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G <input type="checkbox"/> Plan GG <input type="checkbox"/> Plan H <input type="checkbox"/> Plan J <input type="checkbox"/> Child Orthodontia Rider <input type="checkbox"/> Family Orthodontia Rider Underwritten by Dental Health Services: <input type="checkbox"/> SmartSmile <input type="checkbox"/> Super SmartSmile w/ Specialty Dentist# _____	
	Underwritten by Vision Service Plan: <input type="checkbox"/> Signature Plan B <input type="checkbox"/> Choice Plan A	
Prior Medical Coverage (the preexisting condition waiting period is 3 months if applicable; this period may be credited with prior, continuous coverage).		
Prior Medical Carrier and Policy#	List all participants enrolled in prior medical plan:	Duration of coverage: Effective Date: ___/___/___ Termination Date: ___/___/___
Life/AD&D/Disability Plans Underwritten by Regence Life and Health Insurance Company (Amounts above the Guarantee Issue require a completed Evidence of Insurability form). If offered by your employer, enrollment in employer paid Basic Life/AD&D and employer paid Long Term Disability plans is required and you will automatically be enrolled.		
Voluntary Life/AD&D	Increments of \$5,000 to a maximum of \$200,000 In no event shall the combined Basic and Voluntary benefits exceed \$250,000. (Available if employer elects coverage) <input type="checkbox"/> Employee Amount _____ <input type="checkbox"/> Spouse Amount (cannot exceed 50% of employee amount) _____	
Additional Benefit Options	Voluntary Personal Accident: <input type="checkbox"/> Underwritten by Chartis Property Casualty Company Employee Assistance Program: <input type="checkbox"/> Provided by WellSpring Family Services Group Legal Plan: <input type="checkbox"/> 21 st Century Legal Plan (separate form required for Voluntary Personal Accident and Legal Plan; EAP enrollment automatic if offered by your employer)	
EMPLOYEE BENEFICIARY:	Primary Beneficiary Name and Relationship* for Basic Life/AD&D and Supplemental Life and/or AD&D	Primary Beneficiary Address
EMPLOYEE BENEFICIARY:	Contingent Beneficiary Name and Relationship** for Basic Life/AD&D and Supplemental Life and/or AD&D	Contingent Beneficiary Address
* If more than one primary beneficiary is named, the primary beneficiaries shall share equally unless otherwise indicated above. ** Contingent Beneficiary(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. If you are naming more than one Contingent Beneficiary at 100% each, please indicate them in order of precedence.		



Employee and Employer Signature:

I hereby apply for enrollment or change of enrollment as indicated on this application. I understand that the Business Health Trust and the Insurers may collect, use and disclose protected health information about each individual enrolled under this application in order to carry out their routine business functions, including but not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payer, underwriting and conducting case management care management and quality reviews. The Trust and the Insurers may also disclose protected health information to state and federal agencies, or other third parties, as required by law. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.* Health information requested or disclosed may be related to treatment or services performed by: a physician, dentist, pharmacist or other physical or behavioral health care practitioner; a clinic, hospital, long term care or other medical facility; any other institution providing care treatment, consultation, pharmaceuticals or supplies; or an insurance carrier or group health plan. Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

*For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available from the Asuris Northwest Health Web site at www.asurisenorthwesthealth.com or by phone at 1-800-458-3523.

Employee Signature and Date

Employer Signature and Date

Endorsed Carrier Contact Information

- Asuris Northwest Health: 1800 Ninth Ave., Seattle, WA 98101; Customer Service - 800.458.3523
- Group Health Options Inc: 320 Westlake Ave. N., Suite 100, Seattle, WA 98109; Customer Service - 888.901.4636
- Washington Dental Service: 9706 Fourth Ave. N.E., Seattle, WA 98115; Customer Service - 800.554.1907
- Dental Health Services, Inc.: 936 N. 34th Street, Suite 208 Seattle, WA 98103; Customer Service – 800.248.8108
- Vision Service Plan: 600 University St., Suite 2004, Seattle, WA 98101; Customer Service - 800.877.7195
- Regence Life and Health Insurance Company: 100 S.W. Market St., Portland, OR 97201-5702; Customer Service - 877-843-7526
- WellSpring Family Services: 1900 Rainier Ave. South, Seattle, WA 98020; Customer Service – 800.553.7798
- Chartis Property Casualty Company: 2704 Commerce Drive, Suite B, Harrisburg, PA 17110; Customer Service – 877.802.5246
- 21st Century Legal Plan: 401 Second Avenue South, Suite 700 Seattle, WA 98104; Customer Service – 425.882.7805